Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE INCORRECTLY PAID HOSPITALS FOR BENEFICIARIES WHO HAD NOT RECEIVED 96 OR MORE HOURS OF MECHANICAL VENTILATION

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Office of Inspector General

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EXECUTIVE SUMMARY

Medicare incorrectly paid hospital inpatient claims for beneficiaries who had not received 96 or more hours of mechanical ventilation, resulting in $7.7 million of overpayments over 3 years.

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) pays hospital costs at predetermined rates for discharges of Medicare beneficiaries. The rates vary according to the Medicare Severity Diagnosis-Related Groups (MS-DRGs) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. Certain MS-DRGs may be assigned only if a beneficiary has received 96 or more hours of mechanical ventilation. (Mechanical ventilation is the use of a ventilator or respirator to take over active breathing for a patient.) Previous Office of Inspector General reviews of hospitals' compliance with Medicare billing requirements identified erroneous claims with MS-DRGs that required 96 or more hours of mechanical ventilation.

The objective of this review was to determine whether Medicare payments to hospitals for inpatient claims with certain MS-DRGs that required 96 or more hours of mechanical ventilation were correct.

BACKGROUND

The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. For MS-DRGs 207 and 870 to be assigned to a claim, a beneficiary must have received 96 or more hours of mechanical ventilation. A hospital indicates that a beneficiary has met this requirement by using procedure code 96.72. If a beneficiary received fewer than 96 hours of mechanical ventilation, the beneficiary's stay is assigned to an MS-DRG with a lower severity level, resulting in a lower payment.

Our audit covered $12,764,239 in Medicare payments to 290 hospitals for 377 inpatient claims that we selected as at risk for billing errors. These claims had MS-DRGs 207 or 870 and dates of service in calendar years 2009 through 2011 with patient stays in the hospital of 4 days (the equivalent of 96 hours) or fewer.

WHAT WE FOUND

For 14 of the 377 selected claims, Medicare payments to hospitals were correct. However, for the 363 remaining claims, Medicare payments to hospitals were incorrect. Specifically, the hospitals incorrectly used procedure code 96.72 when the beneficiaries had not received 96 or more hours of mechanical ventilation. Consequently, the claims were assigned incorrectly to MS-DRGs 207 and 870, resulting in $7,714,825 of overpayments. The hospitals confirmed that these claims were incorrectly billed and generally attributed the errors to incorrectly counting the number of hours that beneficiaries had received mechanical ventilation or to clerical errors in

selecting the appropriate procedure code. At the time of our audit, CMS did not have controls to identify these erroneous claims.

Prompted by our review, CMS stated that it implemented a new length-of-stay edit for continuous invasive mechanical ventilation for 96 consecutive hours or more. With this edit, effective October 1, 2012, claims found to have procedure code 96.72 and a length of stay fewer than 4 days are returned to the provider for validation and resubmission.

WHAT WE RECOMMEND

We recommend that CMS:

- ensure that the Medicare contractors recover the $7,714,825 in identified overpayments and

- direct the Medicare contractors to review any claims where procedure code 96.72 was used with a length of stay of 4 days or fewer and recover any overpayments after our audit period and before implementation of the length-of-stay edit.

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS partially concurred with our first recommendation and concurred with our second recommendation. CMS stated that it is not possible to recover all of the overpayments because 43 claims are beyond the 4-year reopening period. CMS stated that it would attempt to recover the overpayments for the remaining claims consistent with the agency's policies and procedures.

We encourage CMS to recover the identified overpayments in accordance with its policies and procedures. During our audit, the providers acknowledged that they had billed the claims in error. We advised the providers to submit the adjusted claims to their Medicare contractors. For 24 of the 43 claims noted above, we determined that the Medicare contractors processed adjustments submitted by providers.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) pays hospital costs at predetermined rates for discharges of Medicare beneficiaries. The rates vary according to the Medicare Severity Diagnosis-Related Groups (MS-DRGs) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. Certain MS-DRGs may be assigned only if a beneficiary has received 96 or more hours of mechanical ventilation.[1] Previous Office of Inspector General reviews of hospitals' compliance with Medicare billing requirements identified erroneous claims with MS-DRGs that required 96 or more hours of mechanical ventilation.[2]

OBJECTIVE

Our objective was to determine whether Medicare payments to hospitals for inpatient claims with certain MS-DRGs that required 96 or more hours of mechanical ventilation were correct.

BACKGROUND

The Medicare Program: Administration and Payment of Claims

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for beneficiaries after hospital discharge.

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted for services, conduct reviews and audits, and safeguard against fraud and abuse. As part of claims processing, claim information such as patient diagnoses, procedures, and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated edits that are designed to identify cases that require further review before classification into an MS-DRG.

Medicare Requirements for Hospital Claims and Payments

The Social Security Act (the Act) states that Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (§ 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services without information necessary to determine the amount due the provider (§§ 1814(a) and 1815(a)).

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[1] Mechanical ventilation is the use of a ventilator or respirator to take over active breathing for a patient.

[2] *Medicare Compliance Review of John Muir Medical Center, Walnut Creek, for Calendar Years 2008 Through 2010* (A-09-11-02060), issued February 2012, and *Medicare Compliance Review of University of California, San Francisco, Medical Center for Calendar Years 2008 and 2009* (A-09-11-02034), issued September 2011.

Federal regulations state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

Hospital Inpatient Prospective Payment System and MS-DRG Payments

The Act established the inpatient prospective payment system (IPPS) for inpatient hospital services provided to Medicare beneficiaries (§§ 1886(d) and (g)). Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the MS-DRG to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. Because a patient may undergo a procedure for a variety of reasons, the Medicare contractor uses software to group an admission into a particular MS-DRG on the basis of many factors, including the principal diagnosis, any present accompanying additional diagnosis, and the principal procedure. Therefore, if the hospital reports an incorrect procedure code, the assigned MS-DRG may be incorrect.

MS-DRGs Requiring Beneficiaries To Have Received 96 or More Hours of Mechanical Ventilation

Mechanical ventilation is the use of a mechanical device to inflate and deflate the lungs. Mechanical ventilation provides the force needed to deliver air to the lungs in a patient whose ability to breathe is diminished or lost.

For a beneficiary's stay to be assigned to the following MS-DRGs, the beneficiary must have received 96 or more hours of mechanical ventilation:

- MS-DRG 207 is described as "Respiratory system diagnosis [with] ventilator support 96+ hours."

- MS-DRG 870 is described as "Septicemia or severe sepsis [with mechanical ventilation] 96+ hours."[3]

A hospital indicates that a beneficiary has received 96 or more hours of mechanical ventilation by using procedure code 96.72.[4] If a beneficiary received fewer than 96 hours of mechanical ventilation, the beneficiary's stay is assigned to a lower severity MS-DRG, resulting in a lower payment.[5]

[3] Septicemia is bacteria or other pathogenic organisms in the blood, a condition that often occurs with severe infections. Sepsis is an illness in which the body has a severe response to bacteria or other pathogenic organisms.

[4] *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM), defines procedure code 96.72 as "Continuous invasive mechanical ventilation for 96 consecutive hours or more."

[5] A hospital indicates that a beneficiary has received fewer than 96 hours of mechanical ventilation by using procedure code 96.71.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $12,764,239 in Medicare Part A payments to 290 hospitals for 377 inpatient claims that we selected as at risk for billing errors. These claims had MS-DRGs 207 or 870 and dates of service in calendar years (CYs) 2009 through 2011 with lengths of stay of 4 days or fewer.

For each claim, we evaluated whether the beneficiary had received 96 or more hours of mechanical ventilation as required by the MS-DRG, but we did not use medical review to determine whether the services were medically necessary.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDING

For 14 of the 377 selected claims, Medicare payments to hospitals were correct; the beneficiaries had received 96 or more hours of mechanical ventilation.[6] However, for the 363 remaining claims, Medicare payments to hospitals were incorrect. Specifically, the hospitals incorrectly used procedure code 96.72 when the beneficiaries had not received 96 or more hours of mechanical ventilation. Consequently, the claims were assigned incorrectly to MS-DRGs 207 and 870, resulting in $7,714,825 of overpayments.[7] The hospitals confirmed that these claims were incorrectly billed and generally attributed the errors to incorrectly counting the number of hours that beneficiaries had received mechanical ventilation or to clerical errors in selecting the appropriate procedure code. At the time of our audit, CMS did not have controls to identify these erroneous claims.

FEDERAL REQUIREMENTS

The *Medicare Claims Processing Manual* (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2). In addition, the Manual states that hospitals may bill only for services provided (chapter 3, § 10). Moreover, the Manual states that hospitals must bill Medicare using ICD-9-CM in accordance with its official coding and reporting guidelines (chapter 23, § 10).

[6] Although we selected claims with lengths of stay of 4 days or fewer, the "from" and "through" service dates on these claims did not represent the complete length of stay.

[7] We were unable to determine the amount of the overpayment for 1 of the 363 claims. The hospital is in the process of correcting the claim.

MEDICARE INCORRECTLY PAID HOSPITALS FOR BENEFICIARIES WHO HAD NOT RECEIVED 96 OR MORE HOURS OF MECHANICAL VENTILATION

For 363 of the selected claims, Medicare payments to hospitals were incorrect. The hospitals incorrectly used procedure code 96.72 on the claims when the beneficiaries had not received at least 96 hours of mechanical ventilation. As a result of the incorrect procedure code, the claims were assigned incorrectly to MS-DRGs 207 and 870.

For example, for one beneficiary, the documentation (e.g., time log for the mechanical ventilation) showed that the beneficiary had received 73 hours of mechanical ventilation. However, rather than selecting procedure code 96.71, defined as "continuous invasive mechanical ventilation for less than 96 consecutive hours," the hospital selected procedure code 96.72, indicating that the beneficiary had received 96 hours or more of mechanical ventilation. By using procedure code 96.72, the claim was incorrectly grouped into MS-DRG 870 rather than 871, resulting in an overpayment of $34,506.[8]

As a result of these errors, the hospitals received overpayments totaling $7,714,825. The hospitals confirmed that these claims were incorrectly billed and generally attributed the errors to incorrectly counting the number of hours that beneficiaries had received mechanical ventilation or to clerical errors in selecting the appropriate procedure code. At the time of our audit, CMS did not have controls to identify these erroneous claims.

CMS IMPLEMENTED A NEW LENGTH-OF-STAY EDIT FOR CONTINUOUS MECHANICAL VENTILATION

Prompted by our review, on May 11, 2012, CMS proposed a change to the Medicare Code Editor: the creation of a new length-of-stay edit for continuous invasive mechanical ventilation for 96 consecutive hours or more. CMS stated: "It was brought to our attention that a number of hospitals reporting … procedure code 96.72 … may be inaccurately reporting this code." Consequently, CMS performed an analysis of fiscal year 2011 data:

> … the data show that a total of 245 cases (41 percent) were grouped to MS-DRGs 207 and 870 in error, resulting in approximately $25,000 in increased payments for each case (or approximately $6 million in increased payments for all 245 cases). Based on the results of these figures … there is an even larger dollar amount that is being overpaid to hospitals. These overpayments justify the proposed corrective actions. However, we also note that the presumed amount of overpayments for claims having a length of stay less than 4 days, as discussed above, is merely an estimate based on the data analysis that has been conducted at this time.[9]

[8] MS-DRG 871 is described as "Septicemia or severe sepsis [without mechanical ventilation] 96+ hours [with major complication or comorbidity]."

[9] 77 Fed. Reg. 27870, 27905–27906 (May 11, 2012).

On August 31, 2012, CMS approved the implementation of a new length-of-stay edit for continuous invasive mechanical ventilation for 96 consecutive hours or more. With this edit, effective October 1, 2012, claims found to have procedure code 96.72 and a length of stay fewer than 4 days are returned to the provider for validation and resubmission.[10]

RECOMMENDATIONS

We recommend that CMS:

- ensure that the Medicare contractors recover the $7,714,825 in identified overpayments and

- direct the Medicare contractors to review any claims where procedure code 96.72 was used with a length of stay of 4 days or fewer and recover any overpayments after our audit period and before implementation of the length-of-stay edit.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS partially concurred with our first recommendation and concurred with our second recommendation. CMS stated that it is not possible to recover all of the overpayments because 43 claims are beyond the 4-year reopening period. CMS stated that it would attempt to recover the overpayments for the remaining claims consistent with the agency's policies and procedures. CMS's comments are included in their entirety as Appendix B.

We encourage CMS to recover the identified overpayments in accordance with its policies and procedures. During our audit, the providers acknowledged that they had billed the claims in error. We advised the providers to submit the adjusted claims to their Medicare contractors. For 24 of the 43 claims noted above, we determined that the Medicare contractors processed adjustments submitted by providers.

[10] 77 Fed. Reg. 53258, 53313–53314 (Aug. 31, 2012).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $12,764,239 in Medicare Part A payments to 290 hospitals for 377 inpatient claims that we selected as at risk for billing errors.[11] These claims had MS-DRGs 207 or 870 (both requiring 96 or more hours of mechanical ventilation) and dates of service in CYs 2009 through 2011 with lengths of stay of 4 days or fewer (based on the "from" and "through" service dates).

For each claim, we evaluated whether the beneficiary had received 96 or more hours of mechanical ventilation as required by the MS-DRG, but we did not use medical review to determine whether the services were medically necessary.

We limited our review of CMS's internal controls to those applicable to the inpatient claims for mechanical ventilation. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file.

We conducted our audit from March to December 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with CMS officials to determine which MS-DRGs required 96 or more hours of mechanical ventilation and which internal controls were applicable to inpatient claims for mechanical ventilation;
- extracted inpatient paid claim data from CMS's National Claims History file for CYs 2009 through 2011 for MS-DRGs 207 and 870;
- used computer matching, data mining, and data analysis techniques to identify for review 377 claims with lengths of stay that were 4 days or fewer, which had payments totaling $12,764,239;
- requested that each hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- reviewed the itemized bills and medical record documentation, including the timelog for the mechanical ventilation and summary of the inpatient stay, provided by each hospital

[11] These 290 hospitals are located in 37 States, the District of Columbia, and Puerto Rico.

to determine whether the beneficiaries had received 96 or more hours of mechanical ventilation;

- used CMS's PC Pricer to reprice each improperly paid claim to determine the payment amount for the revised MS-DRG, compared the repriced payment with the actual payment, and determined the value of the overpayment; and[12]

- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[12] CMS's PC Pricer is a tool used to estimate Medicare payments. Because of timing differences in the data used to determine the payments, the estimated payments may not match exactly the actual claim payments.

APPENDIX B: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 2 1 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Incorrectly Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Hours of Mechanical Ventilation" (A-09-12-02066)

Thank you for the opportunity to review and comment on OIG's above-subject draft report. The OIG's main objective was to determine whether Medicare payments to hospitals for inpatient claims with MS-DRGs, 207 and 870 were correct and required 96 or more hours of mechanical ventilation.

As stated in OIG's draft report, CMS has implemented a new length-of-stay edit for continuous invasive mechanical ventilation for 96 consecutive hours or more effective October 1, 2012. The edit will ensure that Medicare does not pay for claims found to have procedure code 96.72 and a length of stay fewer than four days. The claims will be returned to the provider for validation and resubmission. This Change Request (CR) 8041 outlines changes to the Inpatient Prospective Payment System (IPPS) for Acute Care Hospital and the Prospective Payment System (PPS) for Long Term Care Hospitals (LTCHs) for FY 2013.

The findings of this audit, based on Calendar Years (CYs) 2009 through 2011 for MS-DRGs 207 and 870, found that Medicare incorrectly paid hospital inpatient claims for beneficiaries who had not received 96 or more hours of mechanical ventilation, resulting in $7,681,391 of overpayments over three-years.[13] OIG recommends that CMS (1) ensure that the Medicare contractors recover the $7,681,391 in identified overpayments; and (2) direct the Medicare contractors to review any claims where procedure code 96.72 was used with a length of stay of four days or fewer and recover any overpayments after our audit period and before implementation of the length-of-stay edit.

The CMS has reviewed the report and responded to your recommendations below.

[13] **Office of Inspector General Note:** In our draft report, we noted that we were unable to determine the amount of the overpayment for 2 of the 363 claims. After we issued the draft report, the Medicare contractor completed the processing of one of the two claims. Therefore, the total overpayment amount is $7,714,825.

OIG Recommendation

Ensure that the Medicare contractors recover the $7,681,391 in identified overpayments.

CMS Response

The CMS partially concurs with this recommendation because it is not possible to recover all 363 overpayments identified by the OIG. In the overpayment data file, OIG indicated that one overpayment was adjusted by a hospital prior to the issuance of the draft report. Of the remaining 362 sampled claims with overpayments valued at an estimated $7,681,391, forty-three representing an estimated value of $884,986 cannot be reopened as a result of the claims being beyond the four year reopening period. CMS will attempt to recover the remaining 319 overpayments valued at an estimated $6,796,405 consistent with the agency's policies and procedures.

OIG Recommendation

Direct the Medicare contractors to review any claims where procedure code 96.72 was used with a length of stay of four days or fewer and recover any overpayments after our audit period and before implementation of the length-of-stay edit.

CMS Response

The CMS concurs with this recommendation. CMS will direct contractor(s) to review claims from January 2012 through September 30, 2012 where procedure code 96.72 was used with a length of stay of four days or fewer for Acute Care Hospitals and Long Term Care Hospitals. CMS will recover any applicable overpayments.

CMS appreciates the opportunity to comment on this report and we look forward to working with you in the future.